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ABSTRACT

This presentation discusses the effectiveness of a home-visiting program staffed by community workers in providing education and support for parents in poor, underserved areas. Six lessons learned by program staff about ways to successfully implement this type of program are discussed. The first lesson is that it is important to listen to the people who will be served by the program in order to discover their strengths and the needs that most concern them. Second, community workers are a valuable resource when provided with training and support. Third, it is important that the program address a broad range of issues, including health and nutrition, parenting and child development, and the mother's personal development. Fourth, the program needs to network with agencies that provide services other than education and family support. Fifth, it should be expected that the program will be welcomed and well-received, and, sixth, a flexible program that is broad in scope is able to secure funding from diverse sources. (PCB)

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Lessons from the Child Survival/Fair Start Home-Visiting Programs

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The preceding presentations have provided a great deal of detail about the Child Survival/Fair Start programs themselves -- from nitty-gritty aspects of implementation through evaluation methodology, to conclusions about the impacts each program had on participating mothers and infants. Now I want to shift our focus from the trees back to the forest, by reviewing the goals of the overall Child Survival/Fair Start endeavor and then offering my assessment of our collective success meeting those goals. My colleagues and I at the High/Scope Foundation were funded by the Ford Foundation not to run another program, but to coordinate, to provide technical assistance, and as much as possible to encourage the project teams to work toward common goals so we could learn from the entire group of efforts as well as from the individual projects. I think you will agree that these presentations are evidence that we were, as a group, successful in achieving commonality without sacrificing distinctiness.

What was the goal behind the Child Survival/Fair Start grants program? The Ford Foundation program paper that launched the endeavor describes a desire to

> experiment with innovative approaches aimed at increasing access to and use by poor households of available health, nutrition, and child-rearing skills and technology in order to improve their capacity for self-care.

One innovative approach that has proved effective in health programs in developing countries was highlighted:

> the strategy involves the creation and use of a network of community helpers -- the so-called 'peer-to-peer' outreach model.

The rationale for experimenting with community-helper programs in poor underserved communities in the U.S. was first that that approach "should

result in more sensitivity in adapting new practices to local reality", and second that such programs should have a good chance of being sustained locally at relatively modest cost at the end of the Foundation funding.

That general goal leads to two sets of questions. First, could we do it? Could this peer outreach strategy be implemented successfully in the U.S.? What did we learn about doing it well? Secondly, did it work? Did we achieve the goals that we fixed in our sights? What can we conclude from the evaluation results about what appropriate expectations should be for programs using this approach?

Success in implementation

The answer to the first question, "could we do it" is a resounding yes. As you have heard, the Child Survival/Fair Start programs implemented programs using the community-helper appproach in a range of agency settings, in a range of geographic regions, in programs that have been operating for nearly six years. Our five programs have worked in six states and twelve counties, in urban areas (Austin, Fort Lauderdale), and in isolated, rural areas (see Figure 1). They have been operated by small nonprofit organizations, by primary health clinics, and by a major hospital complex. The programs have served both longstanding American communities (in Appalachia, for example) and some of our newest Americans (Haitian and Mexican immigrants). Together, they have made home visits well over 850 families -- half of whom were first-time mothers, one third were teenagers (19 or under), most had less than a tenth grade education, and half had no telephone.

Most significant of all: four of the five programs are continuing to provide services with new, local funding. In some cases the program ideas have been reshaped to respond to local concerns and opportunities. The

Alabama project is using home visitors to reach out to a range of patients, not only pregnant and new mothers but hypertensive patients and those recently discharged from inpatient care. The Haitian project is using the program developed for Haitian mothers to provide follow-up and support to graduates of the NICU, serving families of all races and cultural backgrounds. The Texas project and most of the satellite programs under the MIHOW Appalachian umbrella are continuing. We consider this an impressive achievement.

Lessons learned about doing it well

Along the way, we learned a great deal about what it takes to do this type of program well (by "this type of program" I mean home-visiting programs staffed by community workers, serving the broad needs for education and support of parents in poor underserved areas). When five different project teams work independently toward a common goal, a wealth of experience accumulates. Each project has its own specific stories to tell; what follows is a list of six implementation lessons that arose in several, if not most, of the project experiences (see Figure 2).

The first lesson is that it is important to listen to the people who the program will be serving. We do not typically know as much as we think we know about the lives of the poor people who live in our communities -- the actual conditions of their lives, the needs that most concern them, the strengths they can call on. The Haitian project devoted much of their first year to information-gathering, consulting with anthropologists, doing a survey of the communities they intended to serve, and having their new staff members write at length about Haitian culture, childbearing, and childrearing. The supervisor of the Alabama project commented once that she

wished their team had done something parallel, realizing how much they had left to discover about the people they would serve. Once the project was underway, what the staff learned about the poor rural young people they visited helped shape modifications in the program as it matured.

Second, the experience of these programs shows convincingly, we believe, that community workers can be effective. All the program impacts presented here today were produced through the efforts of paraprofessionals with a moderate amount of preservice training and some ongoing support. As that Appalachian report pointed out, women are an underutilized resource in most poor communities. In every community there are bright, energetic, insightful, and dedicated women (and men) who have not found a role in the work force or been offered an opportunity to make a difference. It is only sensible to use that resource. However, it is essential that community workers be supported. Without the background of professional training, they need the support of a clear sense of what their purpose is, they need solid and continuing training, and they need ongoing one-to-one supervision. With that support, they offer more than their competence, since they can help the program and agency understand the lives, concerns, and strengths of the families they serve.

Third, balance is key to the overall success of multipurpose programs. The Child Survival/Fair Start programs you have heard described address health issues, nutrition issues, in-home health care and use of health care services; they deal with parenting and child development; and many also tackle aspects of the mother's personal development (self-esteem, educational goals, plans for employment, etc.). This breadth is a core strength of this program model, but it is unusual. It goes against the grain. And it is not easy to maintain the multipurpose nature of the program when it is conducted within a single-purpose agency. Programs

within the health care system have to devote extra attention to issues of childrearing and child development if that focus is not to be lost, and programs operating outside the medical care system have to work twice as hard to establish linkages with health care providers to help families address their health needs.

Fourth, and a related point, it is important for programs to network with other agencies and programs to reduce barriers to services, and to increase the relevance and sensitivity of the services that are provided. Families have many needs that an educational or family support program cannot meet, and a strategy must be developed for responding to those needs. Too often, program planners fail to anticipate how important and how time-consuming this aspect of working with families will be. Moreover, community workers do not join the program with a preestablished network of professional contacts, nor are they usually familiar with the range of services available to families. Training, time, and encouragement are required to ensure that the program adequately tackles this responsibility, as well.

Fifth, expect the program to be welcomed. The Child Survival/Fair Start programs were well-received by families, shown in the very low refusal rates experienced in every case. In addition, after the early months when the program was being introduced to the community, clarifying its purposes, and handling turf issues, other agencies usually responded positively, as well. Referral relationships sprang up, often escalating rapidly as other agencies came to see the new program as a resource that could help meet the needs of their clients.

Finally, to meet the challenge of establishing the program locally and attracting stable funding, the Child Survival/Fair Start experience

indicates that it helps to be flexible. The breadth of the program goals that is so challenging in implementation can be a boon when it is time to seek new funds. As we noted, four of the five programs described here have managed to secure independent, post-foundation funding. They did that partly by being creative in the way the programs were conceptualized and marketed. The second-stage home-visiting programs are supported by funding from at least four discrete streams: health care dollars, special education dollars, abuse and neglect prevention dollars, and community development dollars. The program model is a flexible means of responding to many types of problems (or funding opportunities), and that flexibility should be exploited.

An assessment of effectiveness

The second set of questions this summary proposed to address revolve around the issue of effectiveness: does the program approach work, in an evaluation sense? The specific findings are in the project presentations, and only a cryptic summary is offered here. The evaluations searched for program impacts in five key domains: use of prenatal health care, birth status, use of child health care, parenting, and child development. (Please note that because the Texas project did not work prenatally, the first two domains are not relevant to their evaluation).

Overall, the programs did have an impact on use of prenatal health care -- either on prompt initiation of care or on the number of prenatal care visits completed (an indication of both timing and compliance). None budged birth outcomes, however, in large part because both program and comparison groups had normal births. These populations were selected because of a general concern about health and development during early infancy, not because they were at particular risk of low birth weight.

Postnatally, the project evaluations showed that most increased the program mothers' appropriate use of child health care -- shown in more well-child checkups or in more timely immunizations. Several projects had quite strong effects on parenting, for example on mother-child interaction or on provision of a safe, nurturant, stimulating environment for the child. Finally, there were indications (not presented here) that several projects also had a modest impact on infant development.

These evaluation results reveal that the programs influenced the behavior of mothers: their use of preventive health care for themselves and for their children, and their styles of interacting with and providing experiences for their infants. At the same time, no program had effects in all areas. Patterns of effects emerge when a cross-project perspective is adopted. The programs with the strongest effects on the use of health care were, not surprisingly, based in clinics, and the strongest parenting effects came from the programs that were independently organized and that had structured curricula that built in attention to parent-child activities.

The process of reflecting on these evaluation results has also highlighted the fact that a series of conditions must exist in order for any program to demonstrate an effect on outcomes. There must be room for improvement with regard to the outcome of interest. For example, the fact that most of the Child Survival/Fair Start populations bore infants of normal, healthy birth weights meant that it would be unreasonable to expect to see a program impact on birth weight.

The attention and interest of participants must be captured -- topic by topic -- if the program is to have a measurable effect on the outcomes related to those topics. The findings reported here have shown that immigrant groups may be quite responsive to encouragement and assistance regarding health care: a little intervention appeared to go a long way

toward improving the utilization of services by migrant farmworker women, for example. The Appalachian project, working with rural women who have few prospects for education or employment, found participants responded well to the program's messages about parent-child activities. Those messages addressed a role that was of primary importance to the women in the program.

In addition, of course, the program strategy must be well-conceived and culturally appropriate. All the Child Survival/Fair Start programs deliberately built on local traditions and styles of interacting The Texas program for Hispanic-origin famlies consciously included all members of the household and the child's various caregivers (grandmothers, aunts and fathers) in the intervention. In addition, the programs were flexible enough to allow for changes when it turned out that specific components clashed with family needs rather than responding to them. For example, several programs working with teenagers found that for teens with strained relations with their own parents, home visits could be awkward and un-private occasions. In those cases, a walk outdoors or a trip to a fast-food restaurant was substituted for the home visit to maximize the visitor's ability to reach and support the young woman.

Another factor influencing program effectiveness is the potency of the program in relation to the problems it tackles. If a goal is to increase the use of formal services, the program must wield sufficient influence with the service providers to help reduce the institutional barriers that prevent families from coming in. Finally, of course, a good evaluation design and sensitive measures are essential if program effects are to be detected.

Were does this program strategy fit?

The last question posed for this review and synthesis of the Child Survival/Fair Start program experiences concerned appropriate expectations

for programs like these. There is one sense in which we all are both very demanding and very optimistic. We are looking for the answer, we want to find one program approach that will cover all the bases for impoverished and high-risk groups. As I review our experience with the Child Survival/Fair Start programs, it seems most accurate to say that we do not see community-based home-visiting programs as the single response to any significant problem experienced by poor families. However, we do see them as a very important part of responses to a great many different problems. The home-visiting program is able to contribute to improvements in relation to a wide range of problems of maternal health, child health, use of formal services, parenting, and child development.

The conceptual model presented in Figure 3 illustrates our understanding of where the home-visiting program fits in the scheme of things. The program does not act in a vacuum -- community risk characteristics and family risk characteristics continue to drive the problems experienced by infants born into poverty. We are not removing poverty. But we do believe that the home-visiting program can intervene to moderate some of these driving effects.

Of course, the deleterious effects of poverty and risk on children's well-being can also be limited by formal services -- health care, income maintenance, employment programs, social services. The Institute of Medicine just released a new study of strategies to increase the use of prenatal care in which they conclude that the best prospects for improving the use of prenatal care lie in the reorganization of our entire system of maternity care. That reorganization should address such issues as the financing, supply, and quality of prenatal care, as well as access barriers that prevent women from using the care that exists. The report argues that

person-to-person outreach strategies that bring women into care are best-suited as supplements to a well-designed, highly-accessible system of maternity services.

We agree, and the conceptual model includes a box to capture the effects that institutional reform efforts can have, increasing the availability of services, leading to more use of those and consequently to improved child health. Unfortunately, we do not currently have such a well-designed system of maternity care in most parts of the country. And while we waite (and advocate for the reforms proposed by the IOM), babies are being born into poverty, without much benefit even of the inferior health care that exists in their communities. It is a fact that small-scale programs like these do help mothers use the service system that we already have, and we believe that such programs have an important role to play.

Furthermore, the goals and rewards of these programs do not stop with increasing women's use of prenatal care, or of any health services. They offer us a way of sustaining contact with a family both before and after a child's birth. That contact allows us to simultaneously nudge the mother to try new behaviors, nudge her support system and the community to seek ways of helping out, and nudge the health care system to improve its services. Perhaps most importantly, these projects allow us to address health and parenting in an integrated way -- just as families experience them interwoven in the lives of their children.

Finally, I assume many of you have read or heard about Lisbeth Schorr's book <u>Within Our Reach</u>. In that heartening book, Schorr reviews twenty years of experience with programs to combat the effects of poverty. She concludes that we know a great deal about the characteristics of effective programs, and singles out three particular features that they seem to have in common:

1. Successful programs tend to be small, flexible, and interdisciplinary,

2. They pursue client problems across professional and bureaucratic boundaries, and

3. They view the child in the context of his or her family, and view the family in the context of its surrounding community.

The Child Survival/Fair Start home-visiting programs you have now heard so much about share these three characteristics. These are programs that work. They fit well in the stressed communities that house them, they can change a range of key behaviors, and perhaps most important of all, they give a voice to the people they serve.

The Child Survival/Fair Start Home Visiting Programs

5 Programs established in 6 states and 12 counties

- Appalachia (TN, KY, WV)
- Rural Alabama
- South Florida (Haitians)
- South Florida (Migrants)
- Austin, Texas barrios

Home visits made to over 850 women and infants

- Half were first-time mothers
- One-third were teenagers (19 or under)
- Most had less than a 10th grade education
- Half had no telephone

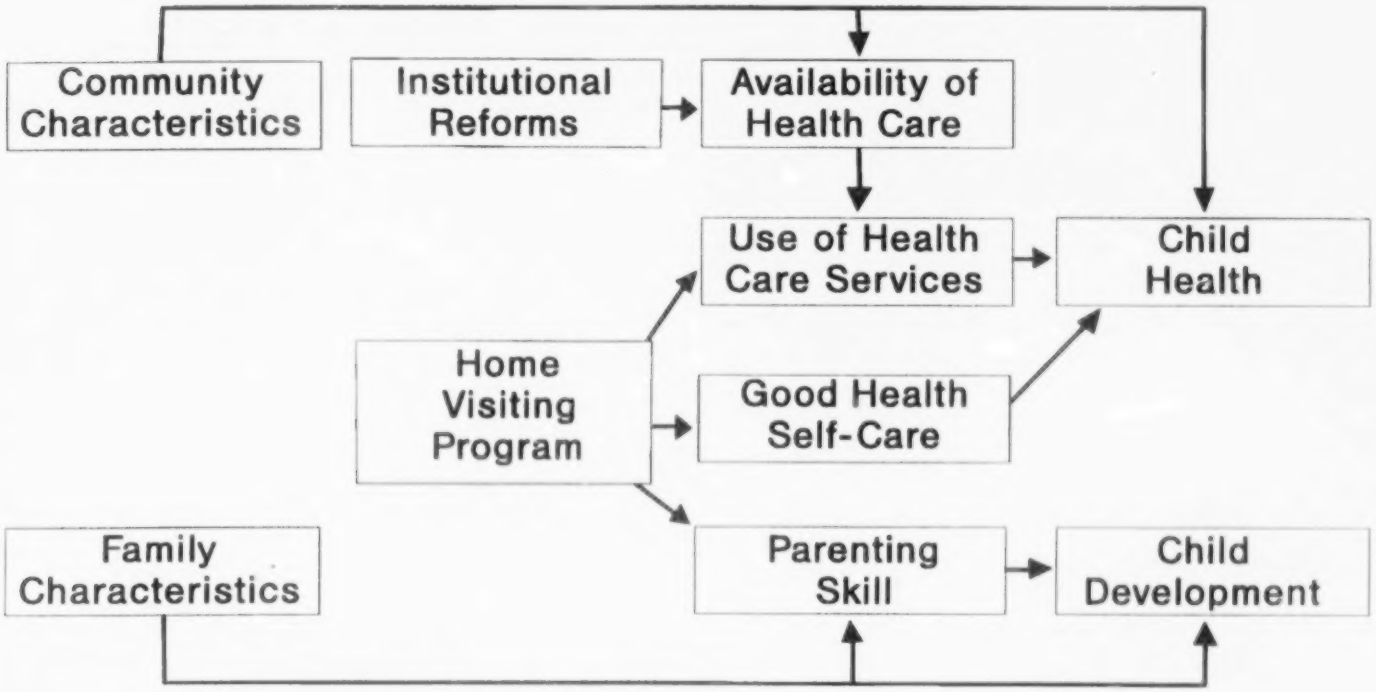
Lessons Learned
About Program Implementation

- LISTEN to poor families to learn about their needs and concerns
- SUPPORT community workers with clear goals, training, and supervision
- BALANCE the effort and attention given to all program goals
- NETWORK with "the system" to open up services for families
- EXPECT the program to be welcomed by families
- USE program ideas flexibly to attract stable funding

What Does It Take To Demonstrate an Effect on Outcomes?

- Room for improvement
- The attention and interest of participants
- An effective strategy that fits local conditions
- Sufficient influence to address institutional barriers
- A good evaluation design

Conceptual Model for Child Survival/Fair Start Home Visiting Programs



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